

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155752		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/18/2013	
NAME OF PROVIDER OR SUPPLIER  MORNINGSIDE NURSING AND MEMORY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 18325 BAILEY AVE SOUTH BEND, IN 46637			
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F000000	<p>This visit was for Recertification and State Licensure Survey. This visit included the Investigation of Complaint #IN00136273.</p> <p>Complaint #IN00136273- Unsubstantiated due to lack of evidence.</p> <p>Survey dates: December 12, 13, 16, 17, and 18, 2013</p> <p>Facility Number: 004732 Provider Number: 155752 AIM Number: 200808300</p> <p>Survey Team: Shauna Carlson, RN - TL Lora Swanson, RN Julie Baumgartner, RN Shelly Vice, RN (12/13 and 12/18, 2013) Pamela Williams, RN (12/12 and 12/13, 2013)</p> <p>Census Bed Type: SNF: 9 SNF/NF: 30 Total: 39</p> <p>Census Payor Type: Medicaid: 30 Other: 9</p>		F000000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000226 SS=D	<p><b>Total: 39</b></p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on December 26, 2013 by Brenda Meredith, R.N.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to follow policy and procedure for screening of new employees for 1 of 5 employee records reviewed. (RN #5)</p> <p>Findings include:</p> <p>On 12/18/13 at 10:35 AM, review of the record for RN (Registered Nurse) #5, hired on 10/17/12, indicated during the hiring process only 1 reference check had been completed.</p> <p>On 12/18/13 at 11:40 AM, interview</p>			F000226	<p>There were no residents affected by this citation. An audit of employee files will be conducted by the Administrator or designee to ensure at least two references have been contacted and documented in the employee file. A checklist is utilized to ensure employee files are complete, including obtaining at least two reference checks. The Administrator or designee is responsible for obtaining reference checks. The checklists for new employees will be reviewed within 10 days of hire to ensure references have been obtained. The Quality Assurance Committee will review the checklists for new employees for three months to determine</p>		01/17/2014

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	<p>with the Administrator indicated it was facility policy to have 2 references completed in employee files.</p> <p>On 12/18/13 at 11:45 AM, review of the "Abuse Prevention and Reporting Policy" received from the Administrator on 12/17/13 at 1:15 PM, indicated "...Applicants will have employment references, professional licensure or certifications,...validated prior to employment to determine if any past history exists relative to their employment history and competency...."</p> <p>On 12/18/13 at 2:44 PM, review of the "Employment Policy" received from the DON (Director of Nursing) at this time indicated "...Each applicant will be screened for a history of abuse, neglect or mistreating residents. This includes requesting information from previous employers, and checking with appropriate licensing boards and registries and at least 2 references verified in writing and maintained in the employee personnel file...."</p> <p>3.1-28(a)</p>		<p>whether or not at least two references have been obtained. If 100% compliance is reached, the monitoring by the Quality Assurance Committee will end.</p>				

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop a plan of care related to nutrition for 1 resident in a sample of 3 reviewed for weight loss. (Resident #33)</p> <p>Findings include:</p> <p>On 12-18-2013 at 11 A.M., review of the "Nutrition Risk Assessment" completed on 7-16-2013 by the RD (Registered Dietician) indicated "...Overall Risk Category: high...."</p> <p>On 12-18-2013 at 11:15 A.M.,</p>		F000279	<p>The care plan for resident #33 was updated to include nutrition or dietary concerns. Other residents who have the potential to be affected were identified through a facility audit conducted by the Dietary Manager. the Dietary Manager was inserviced regarding updating care plans and follow through with physician and/or dietician recommendations as well as other recommendations. The audit will be completed by 1/17/2014. Care plans will be updated within 48 hours following dietician and physician recommendations. If items are added to resident</p>		01/17/2014	

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F000323 SS=D	<p>review of the record for Resident #33 indicated diagnoses included but were not limited to "...seizure disorder, hypokalemia [low potassium], Alzheimer's dementia, depression, anxiety...."</p> <p>On 12-18-2013 2:45 P.M., review of Resident #33 care plans indicated there was no care plan relating to nutrition or dietary concerns. Interview with CDM (Certified Dietary Manager) at this time indicated there were no further care plans related to nutrition for Resident #33.</p> <p>3.1-35(a)</p>			<p>meals, those items will be noted on the care plan to reflect the change in dietary interventions. The Dietary Manager and Registered Dietician are responsible to monitor to assure compliance. The Quality Assurance Committee will review dietary care plans during the quarterly meetings to assure compliance. When the Committee determines 90% compliance, then monitoring will end.</p>			
	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to properly store hazardous chemicals used for cleaning. This deficiency affected 1 of 2 halls.</p> <p>Findings include:</p>		F000323	<p>No residents were affected by this citation. The cabinet in the South Hall community bathroom was locked immediately after the Administrator was notified. A lock was installed on the community shower room door 12/12/2013. The door is self-closing and locks automatically. Residents will not</p>		12/18/2013	

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	<p>On 12-12-2013 at 11:00 A.M., two spray bottles, one labeled SNAP Air Freshener and one labeled RTU Sanitizer, were observed to be in an unlocked overhead cabinet in the south hall community bathroom.</p> <p>On 12-12-2013 at 11:05 A.M., another spray bottle of SNAP Air Freshener and of RTU Sanitizer were observed in an unlocked overhead cabinet in the community shower room in the south hall.</p> <p>On 12-12-2013 at 11:15 A.M., an interview with the Administrator indicated that residents could wander in the bathrooms and shower room.</p> <p>Review of the Hazard Communication Standard Policy received from the Administrator on 12-17-2013 at 1:14 P.M., indicated "1. The facility shall ensure adequate space and storage is made available to effectively contain or separate hazardous waste, chemicals or other materials from other areas of the facility."</p> <p>3.1-45 (a)(1)</p>			<p>be able to enter the shower room unattended. All staff will be inserviced 1/17/2014 regarding safety precautions and observing areas which could pose a safety risks for residents. All staff members will observe the cabinets and shower room on a daily basis to ensure that they remain locked and not accessible to residents. The Director of Nursing, Administrator and department managers will observe the cabinets and shower room during their rounds to ensure that they remain locked and not accessible to residents. they will document on their rounds sheets that they have observed the cabinets and shower room to be locked. Round sheets will be reviewed during the Quality Assurance meetings to ensure compliance. Round sheets are on-going.</p>			

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview and record review, the facility failed to assess, develop and implement dietary interventions for 1 of 3 residents who met the criteria for weight loss since admission. This resulted in weight loss for Resident #33.</p> <p>Finding include:</p> <p>On 12-13-2013 at 11:30 A.M., record review of Resident #33's chart indicated his diagnoses included but were not limited to "...seizure disorder, hypokalemia [low potassium], Alzheimer's dementia, agitation, htn [hypertension - high blood pressure], depression, anxiety...."</p> <p>On 12-13-2013 at 12:35 P.M., interview with LPN #7 indicated Resident #33 was not ordered a</p>		F000325	<p>Interventions for resident #33 have been put into affect which include 560 shakes at breakfast and dinner, ice cream at lunch, and weights monitored weekly. Other residents who have the potential to be affected will be identified through a facility audit completed by the Dietary Manager. Nutrition At Risk (NAR) meetings will be held at least one time weekly and as needed. At the meetings, residents who are at risk for nutrition will be reviewed, and appropriate interventions will be made. The meetings will be attended by the Dietary Manager, Director of Nursing, Administrator and other department managers as deemed appropriate. Minutes for the meeting will be kept. An inservice for appropriate personnel was held during the NAR meeting on 1/9/14. The Quality Assurance Committee will review the minutes for the meetings at least quarterly to ensure compliance.</p>		01/17/2014	

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	<p>nutritional supplement.</p> <p>On 12-13-2013 at 12:45 P.M., review of the record for Resident #33 indicated physician's orders of "...mech soft [mechanically soft]...." diet ordered on 7-15-2013, "...lasix [diuretic] 40 mg [milligrams]...give 1 tablet orally once a day....", and no nutritional supplement had been ordered. Further review of the physician orders indicated "...weight weekly..." starting 9-5-2013. Review of weight log for Resident #33 indicated no weights had been completed between 11-1-2013 and 12-9-2013.</p> <p>An initial "Nutrition Risk Assessment" completed on 7-16-2013 by the RD (Registered Dietician) indicated a height of 70 inches, an admission weight of 209.1 pounds, resulting in a BMI (body mass index) of 30, and a usual body weight of &gt; (greater than) 200 pounds. The assessment also indicated Resident #33 had increased nutritional risk factors related to his diagnoses of Alzheimer's dementia and depression, and was at risk for altered nutrition related to his documented intake being less than 76%. Further review of the</p>						

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	<p>assessment indicated Resident #33 feeds himself.</p> <p>On 12-16-2013 at 2:00 P.M., review of a Nurses Note dated 12-15-2013 indicated "...Alert c [with] confusion per normal for this Resident...Feeds self requiring much more encouragement to eat past few weeks. This nurse attempted to assist c [with] fdg [feeding], resident became agitated...."</p> <p>Review of the weight log indicated that from 11-1-2013 and 12-9-2013, the residents weight went from 219 pounds to 196 pounds, which is an 11.7% weight loss.</p> <p>On 12-18-2013 at 11:12 A.M., review of a fax transmission sheet received from Medical Records employee indicated Resident #33's physician had been notified of weight loss per fax on 12-13-2013 at 5:11 P.M. The fax transmission sheet was a list of 13 residents in the facility, their current weight and their current weight loss percentage. A handwritten note to the physician at the bottom of the fax transmission sheet indicated "[Name of physician] - here are wt [weight] sheets for above residents. Starred residents already have supplement orders...."</p>						

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	<p>Resident #33's name was on the list but did not have a star next to his name, indicated he did not have a nutritional supplement ordered.</p> <p>On 12-18-2013 at 2:00 P.M., review of the dietary note signed by the CDM (Certified Dietary Manager) dated 12-16-2013 indicated "...resident update-resident has had a significant weight loss of 10% in 30 days. Resident is on a mechanical soft diet and is eating 50-75% @ [at] most meals. Resident...sometimes plays in his food instead of eating. Will refer to dietician for follow up and continue to monitor...." Review of the dietary note signed by the RD (Registered Dietician) dated 12-18-2013 indicated "...RD progress note: resident referred 2* [secondary] to experiencing wt [weight] loss of 22.5# [pounds] in 5 weeks...10.3% in 5 weeks...will hold on requesting supplements at this time...if wt loss is insidious or significant, request 60 cc [cubic centimeters] 2 cal [nutritional supplement] med pass QID [four times a day]...."</p> <p>On 12-18-2013 at 2:30 P.M., review of the "Resident at Risk- Weight Committee" policy received from the Administrator on 12-18-2013 at 10</p>						

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F000371 SS=F	<p>A.M. indicated "...for residents who have lost 10 pounds of more, the dietary will prepare '560 shakes' twice daily...."</p> <p>3.1-46 (a)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and record review, the facility failed to distribute and serve food under sanitary conditions. This deficiency had the potential to affect 37 of 37 residents who received meals from 1 of 1 kitchen.</p> <p>Findings include:</p> <p>On 12/17/13 at 12:50 P.M., the Dietary Manager (Employee #2) was observed serving food with her gloved hands, then stopped serving food and began wiping off the residents plastic name cards with a</p>		F000371	<p>No residents were affected by this citation. The policy and procedure for glove usage is posted in the kitchen. The Dietary Manager reviewed the policy and procedure regarding glove usage on 12/19/213. The Registered Dietician will conduct an inservice for the Dietary Manager and dietary staff regarding proper glove usage on 1/8/2014. The dietary staff including the dietary manager will be monitored daily for 2 weeks by the Dietary Manager or designee utilizing a checklist to ensure staff are using gloves properly. Then monitoring will continue at least every 30 days for two months or until 100% compliance is</p>		01/08/2014	

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	<p>paper towel. The Dietary Manager then proceeded to open the oven door and the microwave door with her gloved hands. After opening the oven and microwave door the Dietary Manager did not change her gloves or wash her hands.</p> <p>On 12/18/13 at 10:05 A.M., record review of the current policies titled "Handwashing" and "Disposable Gloves" received from the Administrator indicated "...Appropriate handwashing procedure should be followed: 3. After working with unclean equipment, work surfaces....4. Before preparing or handling food...8. Before and after removing gloves...Handwashing procedures: 2. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for ten (10) to fifteen (15) seconds under a moderate stream of running water, at a comfortable temperature...Disposable gloves will be used when manual contact with ready to eat food is unavoidable...4. Change gloves when they have become soiled, torn or the task is changed. Used gloves are to be discarded. Employees will wash their hands after removing soiled gloves...."</p>			<p>noted. The Quality Assurance Committee will review the checklists at the quarterly meeting to determine compliance. Monitoring of compliance will continue at each Quality Assurance meeting.</p>			

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F000460 SS=E	<p>3.1-21(i)(3)</p> <p>483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident.</p> <p>In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.</p> <p>Based on observation and interview, the facility failed to provide privacy curtains for 4 of 39 beds affecting 4 of 39 residents. (Residents #6, #24, #36, and #27)</p> <p>Findings include:</p> <p>On 12-12-2013 between 11:10 A.M and 11:30 A.M., observation of the beds in Room 100-1, Room 103-2, Room 111-2, and Room 114-1 were not equipped with privacy curtains.</p> <p>On 12-13-2013 at 11:15 A.M., observation of Room 100-1 and Room 114-1 were not equipped with privacy curtains.</p>		F000460	<p>The privacy curtain to room 114-1 was installed on 12/19/2013. A tour of resident rooms to ensure all beds are equipped with privacy curtains was conducted by the maintenance and housekeeping department. There were no other beds without privacy curtains. The housekeeping staff is instructed to observe privacy curtains in all resident rooms on a daily basis. the housekeeping staff was inserviced on 12/18/2013. All staff will be inserviced 1/17/2014. If a privacy curtain is missing, then the housekeeping staff will notify the Administrator or designee so that a replacement curtain can be obtained. The Administrator, Director of Nursing and other department managers will observe for privacy curtains during facility rounds,</p>		12/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155752		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 12/18/2013	
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F009999	<p>On 12-17-2013 at 8:19 A.M., observation of Room 114-1 was not equipped with a privacy curtain.</p> <p>On 12-18-13 at 10 A.M., an interview with Administrator indicated that they did not have a policy related to privacy curtains however it is her expectation that all beds have a privacy curtain.</p> <p>3.1-19 (I)(7)</p> <p>3.1-14 PERSONNEL</p> <p>(q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (7) documentation of orientation to the facility and to the specific job skills.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure documentation of job orientation was complete for 2 of 5 employee</p>		F009999	<p>and will document on their rounds sheets that privacy curtains are equipped in each room and bed. The Quality Assurance Committee will review the rounds sheets for three months to verify that each bed is equipped with a privacy curtain. Facility rounds continue on a daily basis.</p> <p>No residents were affected by this citation. the orientation checklists for employee #1 and employee #4 have been completed. An audit of employee files will be conducted by the administrator or designee to ensure the files are complete to include an orientation checklist and or verification of competency in the employee's specific job duty. A checklist for new employee files includes verification for completion of orientation to specific job duties. The checklists for new employees will be reviewed by the Administrator or designee within 10 days of hire to ensure general and job specific orientation is complete. Personnel responsible for ensuring files are complete were inserviced on 12/19/2013. The Quality Assurance Committee will review the</p>		01/17/2014	

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	<p>records reviewed. (Employee #1 and Employee #4)</p> <p>Findings include:</p> <p>On 12/18/13 at 10:30 AM, review of the record for the DON (Director of Nursing- Employee #1), hired 11/12/12, indicated the "Orientation Checklist" was missing from the file.</p> <p>On 12/18/13 at 10:45 AM, review of the record for CNA #4, hired 10/19/13, indicated the "Orientation Checklist" in her file was signed but not filled out.</p> <p>On 12/18/13 at 11:30 AM, interview with the DON indicated she did not have a copy of the Orientation Checklist completed.</p> <p>On 12/18/13 at 11:35 AM, interview with the Administrator (Employee #6) indicated it was the expectation of the facility to have those completed and in every employee record.</p> <p>On 12/18/13 at 11:45 AM, review of the "Orientation and Inservice Training Policy" received from the Administration (Employee #6) on 11/17/13 at 1:15 PM, indicated "...Verification of general and</p>				<p>checklists of new employees during the quarterly meetings until it is determined that 100% compliance has been achieved.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	specific orientation will be in writing using appropriate facility forms and include acknowledgements by the staff member and training supervisor...."						